

Central MN Sexual Assault Center
Support Group Intake Assessment

Name: _____ Date: _____

Address: _____ Home Phone: _____

City: _____ State: _____ Zip Code: _____ Cell Phone: _____

May we call or leave a message at the telephone numbers given? _____

If not please list a number we can leave a message: _____

How did you hear about this support group? _____

Are you presently employed? _____

What is your occupation? _____

Can you make a 12-14 week commitment to attend a support group? _____

How much of your victimization are you comfortable sharing? _____

What is the perpetrators relationship to you? _____

Have you told anyone? _____ If yes, who? _____

What was their reaction? _____

Was your sexual assault reported? _____

If Yes, What was the outcome? _____

Did you receive any medical care after the sexual assault? _____

How have you been affected by the sexual assault? _____

Have you seen a therapist? _____ If yes, Where? _____

Are you currently attending Therapy? _____

If you are done, how did you feel about the outcome? _____

If the need arises, may we have you sign a release of information for your therapist/counselor?

Have you attended any therapy groups? _____ If yes, Where? _____

Have you attended any support groups or other sexual assault groups? _____ If yes, where? _____

Do you have any health problems? _____ If yes, what? _____

Are you currently under a physicians care? _____ If yes, what type of treatment are you receiving? _____

What is the name of the physician? _____

Are you currently taking any prescribed medication? _____ if yes, please List: _____

If you are taking medications, what are the known side effects? _____

How often do you use alcohol and/or chemicals? _____

Have you ever experienced any negative effects from using alcohol and/or chemicals? _____

If yes, please List: _____

Are you functioning at a level that is satisfying to you (school, work, relationships, etc.)? _____

How do you think this group will help you? _____

Support Group – The primary focus of this group is the exchange of encouragement, motivation, support, information, advice, and understanding between group members who share a common problem.

Therapy Group – The focus of these groups is providing supportive treatment and interpersonal growth.

Do you have any questions or concerns? _____

Signature: _____ Date: _____

Please Return To:
Central Minnesota Sexual Assault Center
15 Riverside Drive Northeast
Saint Cloud, MN 56404-0435
(320) 251-4357 or (800) 237- 5090
E-Mail: CMSAC@CMSAC.ORG

Office use only

Summary: _____

Will start group on: _____

Given copy of: Client Bill of Rights _____
Confidentiality Rights _____
Agency Services _____
Grievance Procedure _____

